AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION



1. I hereby authorize Beth Israel Deaconess Hospital-Milton (BID-Milton), 199 Reedsdale Road, Milton, MA02186 to use or disclose the following health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

2.	Patient Name:	Date of Birth:	_ Date of Birth:/ Phone #:		
	Address:				
	Street Cit	у	State	Zip	
3.	Information to be disclosed to:				
	Address:				
	Street Cit	У	State	Zip	
4.	Disclose the following information for treatment dates:/to:				
	Abstract (i.e History & Physical, Operative/Procedure Reports, Clinic Notes, Discharge Summary, Diagnostic Test Results, Emergency Room Reports)				
	☐ Consultations ☐ Diagnostic Imag	ing Discharge	Summary	ency Reports	
	☐ History & Physical ☐ Laboratory Repo	rts	Notes	ent Reports	
	☐ Pathology Reports ☐ Progress Notes			X-Ray Reports (specify below)	
	Other (specify)				
	☐ Entire Medical Record (additional time and	copying fees may ap	oply)		
5.	The above information is disclosed for the following purp	pose:	are 🗆 Legal 🗆	Insurance	
6.	The means of delivery of the above information shall be:				
	☐ Mail ☐ Fax to: () ☐	E-mail to:		☐ Other	
7.	what format do you want to receive the information?				
8.	I understand I may revoke this authorization at any time by requesting such of the above-referenced hospital, physician, or facility, in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. This authorization expires after ninety (90) days from the date I signed it unless otherwise specified.				
			/		
	Signature of Patient or Legal Representative Date				
	Printed name of Patient or Legal Representative Relationship to Patient/Authority to Act for patient (attach documentation)				
9.	Sign #9 if this pertains to your information. I unders	stand that my record	may contain information	on in reference to treatment	
	for Substance Abuse and/or Alcohol Abuse, Psychiatric treatment, Sexually Transmitted Diseases, Social Service notes,				
	HIV/AIDS, Genetic Testing or other sensitive information. I agree to its release unless otherwise specified (please explain).				
			/ /		
	Signature of Patient or Legal Representative		//	<u> </u>	
	Printed name of Patient or Legal Representative	Relationship to Patient/Authority to Act for patient (attach documentation			